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In the Supreme Court of the United States

OCTOBER TERM, 1992

BOARD OF TRUSTEES OF KNOX COUNTY (INDIANA) HOSPITAL, d/b/a GOOD SAMARITAN HOSPITAL, PETITIONER

v.

LOUIS W. SULLIVAN, SECRETARY OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF FOR THE RESPONDENT IN OPPOSITION

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QUESTION PRESENTED

Under 42 U.S.C. 1395ww(d)(5)(C)(i) (Supp. II 1984), the Secretary of Health and Human Services was directed to "provide for such exceptions and adjustments to the [Medicare] payment amounts established under this subsection as the Secretary deems appropriate to take into account the special needs of regional and national referral centers (including those hospitals of 500 or more beds located in rural areas)." The question presented is whether the Secretary's initial regulation under Section 1395ww(d)(5)(C)(i), which has been superseded, properly limited the availability of adjustments to rural referral centers with more than 500 beds.

TABLE OF CONTENTS

	Page
Opinions below	1
Jurisdiction	1
Statement	2
Argument	6
Conclusion	12

TABLE OF AUTHORITIES

Cases:

Barlow v. *Collins*, 397 U.S. 159 (1970)	7
Sullivan v. *Everhart*, 494 U.S. 83 (1990)	8
Webster v. *Doe*, 486 U.S. 592 (1988)	8

Statutes, regulations and rule:

Administrative Procedure Act, 5 U.S.C. 701(a)(2)	5, 7, 8
Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, Tit. IX, § 9302(d)(1), 100 Stat. 1983-1984	7
Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, Tit. IV, § 4005(d)(1)(a), 101 Stat. 1330-49	7
Social Security Amendments of 1983, Pub. L. No. 98-21, § 601(e), 97 Stat. 152-158	2
42 U.S.C. 1395ww(d)	2
42 U.S.C. 1395ww(d)(1)(A)	2
42 U.S.C. 1395ww(d)(2)	2
42 U.S.C. 1395ww(d)(2)(A)	3
42 U.S.C. 1395ww(d)(2)(D)	3
42 U.S.C. 1395ww(d)(2)(G)	2
42 U.S.C. 1395ww(d)(3)(D)	2, 3
42 U.S.C. 1395ww(d)(4)(A)	2
42 U.S.C. 1395ww(d)(4)(B)	2
42 U.S.C. 1395ww(d)(5)(C)(i) (Supp. II 1984)	3, 5, 6, 7, 8, 9, 10
42 U.S.C. 1395ww(d)(5)(C)(i) (Supp. II 1990)	10
42 U.S.C. 1395ww(d)(5)(C)(ii) (Supp. II 1990)	10

Statutes, regulations and rule—Continued: Page

Spending Reduction Act of 1984, Pub. L. No. 98-369, Tit. II, § 2311(a), 98 Stat. 1076 7
50 U.S.C. 403(c) 8
42 C.F.R.:
Section 405.476(g)(1)(i) (1984) 4, 5
Section 405.476(g)(1)(ii) (1984) 4, 5, 6
Section 412.1 2
Section 412.60 2
Section 412.62 2
Section 412.63 2
Section 412.90(b) 11
Section 412.96 7
Section 412.96(b)(1) 11
Section 412.96(b)(2) 11
Section 412.96(b)(3) 11
Section 412.96(c) 11
Section 412.96(d) 11
Fed. R. Civ. P. 12(c) 5

Miscellaneous:

49 Fed. Reg. (1984):
p. 276 ..... 4, 9
p. 320 ..... 4, 8
pp. 34,761-34,763 ..... 6-7, 9

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. A1-A11) is reported at 965 F.2d 558. The opinion of the district court (Pet. App. A12-A20) is unpublished.

JURISDICTION

The judgment of the court of appeals (Pet. App. A22) was entered on June 25, 1992. A petition for rehearing was denied on July 14, 1992. Pet. App. A21. The petition for a writ of certiorari was filed on October

13, 1992. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. In the Social Security Amendments of 1983, Pub. L. No. 98-21, § 601(e), 97 Stat. 152-158, Congress established a new system for making payments to providers of inpatient hospital services under the Medicare program. Rather than using reasonable cost or customary charges as the basis for payment, the so-called "prospective payment system" provides for payments based on prospectively determined rates that are applied on a per discharge basis. See generally 42 U.S.C. 1395ww(d); 42 C.F.R. 412.1. The payment rates per discharge depend, in large part, on the diagnosis-related group (DRG) in which a patient's treatment is classified. See 42 U.S.C. 1395ww(d)(1)(A). The Secretary is charged with establishing a classification of DRGs and a methodology for assigning discharges to a given DRG. 42 U.S.C. 1395ww(d)(4)(A). The Secretary also must assign a weighting factor to each DRG, based upon the relative hospital resources used by that group. 42 U.S.C. 1395ww(d)(4)(B); 42 C.F.R. 412.60. For each fiscal year, the Secretary establishes prospective payment rates for discharges classified within a particular DRG. See 42 U.S.C. 1395ww(d)(2)(G) and (3)(D).

In calculating prospective payment rates, the Secretary must calculate not only the weighting factor for a DRG, but also the adjusted average standardized costs by which the weighting factors are multiplied. See 42 U.S.C. 1395ww(d)(2) and (3); 42 C.F.R. 412.62, 412.63. The Secretary's cost calculation begins with a base level of actual allowable costs per discharge for

each hospital. '42 U.S.C. 1395ww(d)(2)(A). After making various adjustments required by the statute, the Secretary calculates for each census region separate average standardized amounts for hospitals in urban and rural areas. 42 U.S.C. 1395ww(d)(2)(D) and (3)(D).

Of specific pertinence here, 42 U.S.C. 1395ww(d)(5)(C)(i) (Supp. II 1984), provided during the relevant period that

> [t]he Secretary shall provide for such exceptions and adjustments to the payment amounts established under this subsection as the Secretary deems appropriate to take into account the special needs of regional and national referral centers (including those hospitals of 500 or more beds located in rural areas) * * * .

During the relevant period, the implementing regulations defined a "referral center" in the following manner:

> [The Health Care Financing Administration] will consider a hospital's request for a referral center adjustment to the hospital's prospective payment rates only if the hospital is an acute care hospital that has a provider agreement under Part 489 of this chapter to participate in Medicare as a hospital; and
>
> (i) Is located in a rural area * * * and has 500 or more beds available for use; or
>
> (ii) Has an inpatient population such that at least 50 percent of its Medicare patients are referred from other hospitals or from physicians not on the staff of the hospital. In addition, at least 60 percent of the hospital's Medicare patients must

> live more than 25 miles from the hospital, and at least 60 percent of all the services that the hospital furnishes to Medicare beneficiaries must be furnished to beneficiaries who live more than 25 miles from the hospital.

49 Fed. Reg. 320 (1984) (adopting 42 C.F.R. 405.476 (g)(1)). Under that provision, only hospitals that qualified as "referral centers" under Section 405.476(g)(1)(i)—that is, hospitals with 500 or more beds—were entitled to the higher payment rates applicable to urban hospitals. 49 Fed. Reg. 320 (1984) (adopting 42 C.F.R. 405.476(g)(2)).[1]

2. Petitioner is a rural hospital that provides services under the Medicare program. In its 1984 cost report, petitioner sought a higher Medicare reimbursement as a rural referral center. Petitioner has 344 beds and was therefore ineligible for treatment as a 500-bed referral center under 42 C.F.R. 405.476(g)(1)(i) (1984). The Secretary's fiscal intermediary denied petitioner's request for higher payments, and the Provider Reimbursement Review Board affirmed. Pet. App. A2.

3. Petitioner then filed this action challenging the Secretary's decision not to provide increased payments to rural "referral centers" with fewer than

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[1] Under the original final regulation, the Secretary did not provide higher reimbursements for any hospitals that qualified as rural "referral centers" pursuant to Section 405.476(g)(1)(ii). The inclusion of that provision was initially designed to gather data to help determine whether a higher rate was warranted for the kind of referral center defined in that subsection. Pet. App. A5; see 49 Fed. Reg. 276 (1984).

500 beds. The district court granted the Secretary's motion for judgment on the pleadings under Fed. R. Civ. P. 12(c). The court determined that the Secretary's definition of "referral center" under 42 C.F.R. 405.476(g)(1)(i) and (ii) (1984) was rational and consistent with the statute. Noting that petitioner did not contend that it satisfied the definition of a "referral center" under Section 405.476(g)(1)(i) or (ii) (1984), the court held that petitioner lacked standing to contest the fact that higher reimbursements were available under subsection (i) but not subsection (ii). Pet. App. A16-A18. In the alternative, the trial court concluded that the Secretary's action was committed to agency discretion and was therefore unreviewable under the Administrative Procedure Act (APA), 5 U.S.C. 701(a)(2). Pet. App. A18-A20.

4. The court of appeals affirmed on other grounds. The court concluded that petitioner had standing to challenge the Secretary's denial of its reimbursement claim under the Medicare statute. Pet. App. A2-A5. The court also found that the Secretary's promulgation of the challenged regulation was not a matter committed to agency discretion within the meaning of the APA. Pet. App. A5-A8. The court held, however, that the regulatory limitation on the availability of higher reimbursement was "reasonable and consistent with the statute." *Id.* at A12.

The court noted that 42 U.S.C. 1395ww(d)(5)(C)(i) (Supp. II 1984) referred to "regional and national referral centers." The court reasoned that this phrase might have been understood to refer only to large facilities typically found in urban centers; hence, in the court's view, the parenthetical phrase—

"including those hospitals of 500 or more beds located in rural areas" (42 U.S.C. 1395ww(d)(5)(C)(i) (Supp. II 1984))—may have been added to ensure that such hospitals, like those in urban areas, were eligible for higher compensation. Pet. App. A10.

In addition, the court observed that the legislative history reflected an expectation that the Secretary would gather information about referral centers in order to assist the formulation of appropriate criteria. Thus, the court held that for 1984—the initial year of the program—the Secretary reasonably limited the higher payments to referral centers having 500 or more beds (the category explicitly mentioned in the statute), while gathering more information on referral centers that met the criteria in subsection (ii) of the regulation. Pet. App. A9-A11.

ARGUMENT

Petitioner renews its contention that the rule applicable to its 1984 cost report was inconsistent with the statute because it made higher reimbursements available only to rural referral centers with 500 or more beds. Pet. 4-11. That claim does not merit further review. The decision of the court of appeals is correct and does not conflict with any decision of this Court or any court of appeals. In addition, the statute and regulation at issue have been amended;[2] thus, the question presented in this case is without continuing importance.[3]

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[2] For cost reporting periods beginning on October 1, 1984, the Secretary revised the relevant regulation to provide for increased availability of adjustments to referral centers and more generous criteria for qualifying as a referral center. 49

The court of appeals correctly concluded that the Secretary's initial approach of limiting higher reimbursement rates to referral centers with 500 or more beds did not offend the statute. The relevant statutory provision directs the Secretary to "provide for such exceptions and adjustments to the payment amounts established under this subsection as the Secretary deems appropriate to take into account the special needs of regional and national referral centers (including those hospitals of 500 or more beds located in rural areas)." 42 U.S.C. 1395ww(d)(5)(C)(i) (Supp. II 1984). As petitioner concedes (Pet. 4), that provision is ambiguous. Thus, even assuming that the matter is not "committed to agency discretion by law" (5 U.S.C. 701(a)(2)),[4] the now-superseded reg-

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Fed. Reg. 34,761-34,763 (1984). As subsequently amended and renumbered, the referral center regulation is now codified at 42 C.F.R. 412.96. The relevant statutory provision has also been amended on several occasions. See, *e.g.*, Spending Reduction Act of 1984, Pub. L. No. 98-369, Tit. III, § 2311(a), 98 Stat. 1076; Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, Tit. IX, § 9302(d)(1), 100 Stat. 1983-1984; Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, Tit. IV, § 4005(d)(1)(a), 101 Stat. 1330-49.

[3] In fact, petitioner has been reclassified as a "referral center" and now receives more generous Medicare payments. The only issue in this case is petitioner's reimbursement for the 1984 cost reporting year. Pet. App. A1 n.1.

[4] We believe that the district court correctly determined (Pet. App. A18-A20) that the issue in this case is committed to agency discretion within the meaning of 5 U.S.C. 701(a)(2). That issue is not what constitutes a "referral center"—a matter as to which there is law to apply. Cf. *Barlow* v. *Collins*, 397 U.S. 159, 166 (1970). Rather, as the district court found (Pet. App. A18), the issue is the Secretary's initial decision not to

ulation that petitioner challenges must be sustained if it is "rational and consistent with the statute." *Sullivan* v. *Everhart*, 494 U.S. 83, 89 (1990).

The court of appeals properly held that the line drawn by the Secretary's January 3, 1984, initial final rule (see 49 Fed. Reg. 320 (1984))—between rural hospitals with 500 or more beds and those with fewer than 500 beds—was rational and consistent with 42 U.S.C. 1395ww(d)(5)(C)(i) (Supp. II 1984). When the

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increase the compensation for any rural "referral center" having fewer than 500 beds. As to that, the relevant statutory provision states that the Secretary shall provide "such exceptions and adjustments to the payment amounts * * * as the Secretary *deems appropriate*." 42 U.S.C. 1395ww(d)(5)(C)(i) (Supp. II 1984) (emphasis added). As this Court said of a similarly phrased statute in *Webster* v. *Doe*, 486 U.S. 592, 600 (1988), "[t]his standard fairly exudes deference * * * and appears * * * to foreclose the application of any meaningful judicial standard of review." The statute in *Webster* allowed the Director of Central Intelligence to terminate an employee whenever he "shall *deem* such termination necessary or advisable in the interests of the United States." 50 U.S.C. 403(c) (emphasis added). This Court reasoned that "[s]hort of permitting cross-examination of the [DCI] concerning his views of the Nation's security and whether the discharged employee was inimical to those interests, we see no basis on which a reviewing court could properly assess an Agency termination decision." 486 U.S. at 600. The same is true here; short of cross-examining Secretary Heckler concerning her views of the appropriateness of temporarily providing adjustments only to rural referral centers with 500 or more beds, there is no meaningful basis for evaluating compliance with 42 U.S.C. 1395ww(d)(5)(C)(i) (Supp. II 1984). As was the case in *Webster*, the statutory language here "strongly suggests that its implementation was 'committed to agency discretion by law.'" 486 U.S. at 600 (quoting 5 U.S.C. 701(a)(2)).

applicable final rule was promulgated, the Secretary reasonably concluded that additional information was needed before determining the appropriate adjustments for rural referral centers with fewer than 500 beds. As the Secretary explained:

> Since there is no generally accepted definition of referral centers, it is not possible at this time to determine which payment adjustments are appropriate. This is because we will not know how referral center costs are atypical when compared to other hospitals until we have an opportunity to examine and analyze in detail the data pertaining to those hospitals (other than large rural hospitals) which apply for referral center status. Only when we have completed an analysis will we be able to determine in what ways referral centers are atypical when compared to other hospitals with respect to their costs, and then to develop an appropriate adjustment.

49 Fed. Reg. 276 (1984).

Accordingly, the initial final rule—which was amended soon after it was promulgated (49 Fed. Reg. 34,761-34,763 (1984))—rationally omitted adjusted payments for any rural referral centers except for those that Congress had explicitly identified for inclusion as "referral centers" under the statute—"those hospitals of 500 or more beds located in rural areas" (42 U.S.C. 1395ww(d)(5)(C)(i) (Supp. II 1984)).[5] Because

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[5] As the court of appeals explained, because 42 U.S.C. 1395ww(d)(5)(C)(i) (Supp. II 1984) was designed to address "the special needs of regional and national referral centers," that provision may be understood to refer generally to "large

the initial final rule was reasonably based upon the lines drawn by the statute itself—and because there is no conflict among the circuits on the construction of 42 U.S.C. 1395ww(d)(5)(C)(i) (Supp. II 1984)—further review is unwarranted.

In any case, the decision below is without continuing importance, because the statute and regulation have both been amended in a manner that clarifies the proper treatment of rural hospitals. Under 42 U.S.C. 1395ww(d)(5)(C)(i) (Supp. II 1990), "regional and national referral centers" are deemed to "includ[e] those hospitals of 275 or more beds located in rural areas." In addition, the amended statute clarifies the factors to be used in classifying rural hospitals as regional referral centers (42 U.S.C. 1395ww(d)(5)(C) (ii) (Supp. II 1990)):

> The Secretary shall provide, under clause (i), for the classification of a rural hospital as a regional referral center if the hospital has a case mix index equal to or greater than the median case mix index for hospitals * * * located in an urban area in the same region * * *, has at least 5,000 discharges a year, or, if less, the median number of

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facilities, ones 'regional' and 'national' in scope." Pet. App. A10. The parenthetical phrase—"including those hospitals of 500 or more beds located in rural areas"—merely made clear that certain large rural hospitals should be treated as "referral centers" under the statute. See *ibid.* Contrary to petitioner's suggestion (Pet. 9-10), it does not follow from the use of the term "including" that Congress also necessarily intended to *require* the Secretary to treat certain other rural hospitals, with fewer than 500 beds, as "referral centers" entitled to higher reimbursements.

> discharges in urban hospitals in the region in which the hospital is located * * * , and meets any other criteria established by the Secretary under clause (i).

The presently effective regulations, moreover, generally provide that the Health Care Financing Administration may adjust prospective payment rates if a hospital acts as a referral center. See 42 C.F.R. 412.90(b). A hospital's status as a referral center, in turn, depends upon (1) the number of beds in a rural hospital (42 C.F.R. 412.96(b)(1)); (2) the percentage of Medicare patients who are referred from other hospitals or who live more than 25 miles from the hospital (42 C.F.R. 412.96(b)(2)); or (3) a rural hospital's ability to meet a combination of criteria relating to case mix, number of discharges, and either medical staff, source of inpatients, or volume of referrals (42 C.F.R. 412.96(c)). For discharges occurring on or after April 1, 1988, rural hospitals that meet any one of those three sets of standards are paid based on applicable urban rates. 42 C.F.R. 412.96(d). Thus, the question presented by petitioner, which concerns a now-superseded regulation that implemented a prior version of the relevant statutory provision, is of no continuing importance.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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